Appendix 9
UB-92 Claim Form Completion Instructions for Inpatient Hospital Services

Use these billing instructions to avoid denied claims or inaccurate claim payment. Enter all required data on the UB-92 claim form in the appropriate data item. Do not include attachments. UB-92 items are required unless "optional" or "not required" is specified.

These instructions are for the completion of the UB-92 claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Unified Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

For more information, go to the NUBC web site at *www.nubc.org/*.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at www.dhfs.state.wi.us/medicaid/ for more information about the EVS.

Item 1* — Provider Name, Address, and Telephone Number
Enter the name of the hospital submitting the claim and the complete mailing address to which the hospital wishes payment sent. Include the hospital city, state, and ZIP code.

Item 2 — ERO Assigned Number (required, if applicable)
Enter the Pre-Admission Review control number if required.

Item 3 — Patient Control No.
Enter the patient's control number.

Item 4 — Type of Bill
Enter the three-digit type of bill number. The bill number for inpatient hospitals is:

111 = Hospital, Inpatient, Admit through Discharge Claim

Item 5 — Fed. Tax No. (Not required)

Item 6 — Statement Covers Period (from - through)
Enter both dates in MMDDYY format (e.g., May 9, 2003, would be 050903).

Item 7 — COV D.
Enter the total number of days covered by the primary payer, as qualified by the payer organization such as commercial health insurance or Medicare. Do not count the day of discharge.

Item 8 — N-C D.
Enter the total noncovered days by the primary payer. The sum of covered days and noncovered days must equal the number of days in the "from - through" period.

Item 9 — C-I D (Not required)

Item 10 — L-R D (Not required)

Item 11 — Unlabeled Field (reserved for state use)

Item 12 — Patient Name
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

*Items are also referred to as "Form Locators" in the UB-92 Billing Manual.

Item 13 — Patient Address (not required)

Item 14 — Birthdate (not required)

Item 15 — Sex (not required)

Item 16 — MS (not required)

Item 17 — Admission Date
Enter the admission date in the MMDDYY format (e.g., 050103).

Item 18 — Admission HR (not required)

Item 19 — Admission Type
1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn

Item 20 — Admission SRC
Enter the code indicating the source of this admission. Refer to the UB-92 Billing Manual for more information on this item.

Item 21 — D HR (not required)

Item 22 — STAT
Enter the code indicating patient status as of the "Statement Covers Period" through date (Item 6).

Item 23 — Medical Record No.
Enter the number assigned to the patient's medical/health record by the provider.

Items 24-30 — Condition Codes (required, if applicable)

Item 31 — Unlabeled Field (reserved for state use)

Items 32-35 a-b — Occurrence (Codes and Dates) (Required, if applicable)

Item 36 — Occurrence Span (Codes and From-Through) (required, if applicable)

Item 37 a-c — Unlabeled Field (reserved for state use)

Item 38 — Unlabeled Field (reserved for state use)

Items 39-41 a-d — Value Codes (Codes and Amounts) (required, if applicable)

Item 42 — REV. CD.
Enter the revenue code which identifies a specific accommodation, ancillary service, or billing calculation.

Item 43 — Description
Enter a description for the revenue code(s) listed in Item 42.

Item 44 — HCPCS/Rates (required, if applicable)
Enter the rate for each accommodation revenue code indicated.

Item 45 — Serv. Date (not required)

Item 46 — Serv. Units
Enter the total number of covered accommodation days, ancillary units of service, or visits, where appropriate.

Item 47 — Total Charges
Enter the total charges pertaining to the related revenue code for the current billing period as entered in Item 6.

Item 48 — Non-covered Charges (not required)

Item 49 — Unlabeled Field (reserved for state use)

Item 50 A-C — Payer
Identify all third-party payers (including Medicare and commercial health insurance). Enter "T19" for Wisconsin Medicaid and "MED" for Medicare. For a list of identifiers for commercial health insurance, refer to the UB-92 Billing Manual.

Item 51 A-C — Provider No.
Enter the number assigned to the provider by the payer indicated in Item 50 A, B, and C.

Item 52 A-C — Rel Info (not required)

Item 53 A-C — Asg Ben (not required)

Item 54 A-C — Prior Payments (required, if applicable)
There must be a dollar amount or $0.00 reported here for the third-party payer identified in Item 50. Do not indicate any Medicare payments.

Item 55 A-C — Est Amount Due (not required)

Item 56 — Unlabeled Field (reserved for state use)

Item 57 — Unlabeled Field (reserved for state use)

Item 58 A-C — Insured's Name
If submitting a claim for a newborn and using the mother's Medicaid identification number, both the mother's name and birth date should be indicated here.

Item 59 A-C — P. Rel (not required)

Item 60 A-C — Cert. — SSN — HIC. — ID No.
Enter the recipient's 10-digit Medicaid identification number as it appears on his/her identification card.

Note: When the hospital stay involves a birth(s), each baby's charges must be submitted on a separate claim form. If the entire stay is less than 11 days, the hospital may submit the baby's claim using the mother's Medicaid identification number, identifying the baby's sex with occurrence code 50 or 51 and indicating the occurrence (birth) date. Otherwise, the claim should be submitted using the baby's Medicaid identification number, once assigned.

Item 61 A-C — Group Name (not required)

Item 62 A-C — Insurance Group No. (not required)

Item 63 A-C — Treatment Authorization Codes (required, if applicable)
Indicate the approved seven-digit Wisconsin Medicaid prior authorization number.

Item 64 — Esc (not required)

Item 65 — Employer Name (not required)

Item 66 — Employer Location (not required)

Item 67 — Prin. Diag. CD.
The principal diagnosis code identifies the condition chiefly responsible for the patient's visit or treatment. Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Any condition which is not manifested upon admission or that develops subsequently should not be selected as the principal diagnosis.

Manifestation codes are not to be recorded as the principal diagnosis; code the underlying disease first. The principal diagnosis code may not include "E" codes. "V" codes may be used as the principal diagnosis, *unless restricted by the payer*.

Items 68-75 — Other Diag. Codes (required, if applicable)
Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Diagnoses which relate to an earlier episode and which have no bearing on this episode are to be excluded.

Item 76 — Adm. Diag. Cd.
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Item 77 — E-Code (not required)

Item 78 — Unlabeled Field (reserved for state use)

Item 79 — P.C. (not required)

Item 80 — Principal Procedure Codes and Dates (required, if applicable)
Enter the ICD-9-CM surgical procedure code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

Note: Most often the principal procedure will be that procedure which is most closely related to the principal discharge diagnosis.

Item 81 — Other Procedure Codes and Dates (required, if applicable)
If more than six procedures are performed, report those that are most important for the episode using the same guidelines for determining principal procedure (Item 80).

Item 82 a-b — Attending Phys. ID

Enter the Unique Physician Identification Number or license number and name.

Item 83 a-b — Other Phys. ID (not required)

Item 84 a-d — Remarks (enter information when applicable)

Enter third-party insurance (commercial insurance coverage) unless the service does not require third-party billing. Third-party insurance must be billed before billing Wisconsin Medicaid.

Other Insured's Name

Providers must bill commercial health insurance before billing Wisconsin Medicaid unless the service does not require health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook. Leave this item blank when the following applies:

- The provider has not billed the commercial health insurance because eligibility verification did not indicate other coverage.
- The service does not require commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook.
- Eligibility verification indicates "DEN" only.
- When eligibility verification indicates "HPP," "BLU," "WPS," "CHA," or "OTH," and the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, indicate one of the following codes:

Code	*Description*
OI-P	Use the OI-P disclaimer code when the recipient's health insurance pays any portion. The claim indicates the amount paid by the health insurance company to the provider or the insured.
OI-D	Use the OI-D disclaimer code only when these three criteria are met: √ Eligibility verification indicates "HPP," "BLU," "WPS," "CHA," "DEN," or "OTH." √ The service requires billing health insurance before Wisconsin Medicaid. √ The charges have been billed to the health insurance company and the insurance company has denied them.
OI-Y	Use the OI-Y disclaimer code when the identification card indicates other coverage but the insurance company was not billed for reasons including: √ The provider knows the service in question is not covered by the insurer (i.e., has a previous denial). √ Insurance failed to respond to a follow-up claim.

When eligibility verification indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated, if applicable:

Code	*Description*
OI-P	Use the OI-P disclaimer code when the health insurance pays any portion. The amount paid is indicated on the claim.
OI-H	Use the OI-H disclaimer code only when these two criteria are met: √ Eligibility verification indicates "HMO" or "HMP." √ The HMO or HMP does not cover the service or the billed amount does not exceed the coinsurance or deductible amount.
Note:	Providers may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not provided by a designated provider. Wisconsin Medicaid does not reimburse services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

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(Continued)

Medicare must be billed before Wisconsin Medicaid. Indicate a Medicare disclaimer code if both the following statements are true:

- Medicare covers the procedure at least sometimes.
- The recipient's Wisconsin Medicaid eligibility verification shows he or she has Medicare coverage for the service performed. For example, the service is covered by Medicare Part A and the recipient has Medicare Part A.
- The nonphysician provider's Wisconsin Medicaid file shows he or she is Medicare certified. (If necessary, Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.

Code *Description*

M-1 Medicare benefits exhausted. Use this code when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service performed is covered by Medicare Part A but is not payable due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

M-5 Provider is not Medicare-certified. Use this code when the provider is identified in Wisconsin Medicaid files as being Medicare certified but the provider is billing for dates of service before or after his or her Medicare certification effective dates.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is not certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):

- The provider is not certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-6 Recipient not Medicare-eligible. Use this code when Medicare denies payment for services related to chronic renal failure because the recipient is not eligible for Medicare. Bill Medicare first even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare.

Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 Medicare disallowed or denied payment. Use this code when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare Part B.

M-8 Noncovered Medicare service. Use this code when Medicare was not billed because the service, under certain circumstances (for example, diagnosis), is not covered.

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A, but not under certain circumstances (for example, diagnosis).

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B, but not under certain circumstances (for example, diagnosis).

Leave the element blank if Medicare is not billed because eligibility verification indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefits to the claim and leave this element blank. Do not enter Medicare paid amounts on the claim form. Refer to the Claims Submission section of the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Item 85 — Provider Representative

Enter an authorized signature indicating that the information entered on the face of this claim is in conformance with the certification on the back of this claim. A facsimile signature is acceptable.

Item 86 — Date

Enter the date on which the claim is submitted to the payer.